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POLICY ESSAY

WHY WE MUST END INSURANCE DISCRIMINATION AGAINST MENTAL HEALTH CARE

REPRESENTATIVE PATRICK J. KENNEDY*

In this Policy Essay, Representative Patrick Kennedy argues that insurance discrimination against those suffering from mental illnesses constitutes a serious and often overlooked deficiency of the modern American health care system. While the Mental Health Parity Act of 1996 was an important step toward resolution of this issue, many loopholes remain that allow insurance companies to deny much-needed coverage to those suffering from such illnesses. This Essay details how improving access to health insurance for the mentally ill is not only socially beneficial, but also economically sound; the cost of instituting mental health parity is far outweighed by the costs that employers bear because of the reduced productivity of untreated mental illness sufferers. Representative Kennedy recommends that these problems may be addressed by additional mental health parity legislation—specifically, the proposed Paul Wellstone Act.

I was less than a year old when my Uncle Bobby was assassinated. That year, in which Martin Luther King, Jr. also lost his life and President Nixon rode the "Southern Strategy" to victory, marked the denouement of what would later be known as the Civil Rights Era. The Movement had realized its landmark achievements in 1964 and 1965 with the passage of the Civil Rights Act and the Voting Rights Act. As the decade drew to a close, the war in Vietnam had eclipsed civil rights as the dominant social issue.

During the era's zenith, my uncles and father helped midwife some of the most significant advances in social justice in a century. I entered public service in the late 1980s eager to continue the struggle for civil rights that is my family's legacy. But by 1994, when I was elected to Congress, the great causes of the past seemed quite remote. Along with many of my fellow Democrats, I focused on beating back the "Republican revolution," which swept into power a new congressional majority ideologically hostile to most of the achievements of the twentieth century that liberal

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Democrats hold dear. As President Clinton would famously declare later, the era of big government was over.[1]

It is a measure of the invisibility of the issue of mental health that I, who was careful at the time to keep my own depression private, failed to see the pervasive discrimination against those with mental illness for what it is. I have come to realize that there is a civil rights struggle remaining to be fought on behalf of the 44 million adults and 6 to 9 million children in the United States with diagnosable mental illnesses.[2] In a society where millions must hide debilitating diseases for fear of prejudice, where potentially life-saving health care is routinely denied to a disfavored class, where states have policies requiring parents to give up custody of mentally ill children as a condition of treating them,[3] there are plenty of opportunities to strike a blow for justice. At the heart of this cause is "mental health parity" legislation to end health insurance discrimination against those with mental illness.

Some Background on Mental Health in the United States

The treatment of mental illness has been consistently located on the fringes of the health care system in this country. The persistent belief that mental and physical well-being are unconnected, derived from Rene Descartes's theories about the separation of mind and body, continues to fuel the stigmatization surrounding mental health care.[4] Because treatment of the mind—and thus the status of mental health—has been considered non-scientific and non-medical, mental illnesses have historically been regarded as shameful personal failings, rather than treatable diseases.

During the colonial era, mental illness was primarily addressed by individual families.[5] As urbanization took hold across the country in the late eighteenth century, local and state governments were forced to address the problem.[6] They responded by building the first mental health facilities, also known as asylums, and by pioneering new methods of treatment.[7] Though initially successful, the quality of care at many asylums soon dete-

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[1] Address Before a Joint Session of the Congress on the State of the Union, 54 Pub. Papers (Jan. 23, 1996).

[2] U.S. Dep't of Health & Human Servs., Mental Health: A Report of the Surgeon General 46, 179 (1999) [hereinafter SGRMH].

[3] U.S. Gen. Accounting Office, Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services 11 (Apr. 2003), *available at* http://www.gao.gov/new.items/d03397.pdf.

[4] SGRMH, *supra* note 2 at 2. Descartes believed that, whereas physicians could tend to the physical body, the mind implicated the spiritual and should be ministered to by religion. *See id.*

[5] *Id.* at 75.

[6] *See id.*

[7] *See id.* at 78.

riorated as the promise of these treatments failed to meet expectations.[8] The situation was further complicated when local governments, in an effort to avoid spending public funds on mental health, began housing patients afflicted with mental illnesses in almshouses and jails.[9]

The early twentieth century brought a period of rapid change in the treatment of mental illness.[10] In the early 1900s, State Care Acts were passed centralizing the financial responsibility for the mentally ill within state governments.[11] The care provided in newly established state asylums varied greatly; often, funding was inadequate and asylums functioned as long-term housing rather than as treatment centers.[12] During this "Mental Hygiene" reform period, institutions that housed the mentally ill were renamed mental hospitals and there was a growing focus on prevention and treatment, and interest in the science of mental illness.[13] The reality for those with mental disorders did not change significantly, however, as mental hospitals administered varying levels of humane care, often maintained appalling conditions, and provided little successful treatment.[14]

A newfound optimism about the potential for treating mental illnesses, stemming from advances made by military mental health services during World War II, led to widespread deinstitutionalization beginning in the 1950s.[15] Passage of the Mental Retardation Facilities and Community Mental Health Center Construction Act in 1963 accelerated the process and heralded a shift in mental health care funding to community-based resources.[16] By the 1970s, the prevailing wisdom returned, in a sense, to the original colonial approach—that those with mental illness could best be treated in their communities.[17]

Today, unfortunately, many of the support services necessary to make a community-based system successful—housing, disability payments, and vocational opportunities—are poorly coordinated and largely unavailable to those without financial resources.[18] Over the years, the mentally ill and their families have waged individual battles to cobble together programs and services to meet individual needs.[19] Though a noble attempt to integrate sufferers into society, the modern deinstitutionalization movement gave rise to a makeshift mental health system largely separate from—and inferior to—the greater health care system.[20]

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[8] *See id.*
[9] *See id.*
[10] *See id.*
[11] *See id.*
[12] *See id.*
[13] *See id.*
[14] *See id.*
[15] *See id.*
[16] Pub. L. No. 88-164, 77 Stat. 282 (1963).
[17] SGRMH, *supra* note 2, at 79–80.
[18] *See id.* at 80.
[19] *See id.*
[20] *See id.*

Thus the archaic distinction between mental and physical health remains potent today, as does the resulting stigma.[21] To see what the legacy of this history looks like in 2004, examine the terms of your health insurance policy. The great likelihood is that even if you have a Cadillac plan, your policy covers fewer days in the hospital and fewer outpatient visits for mental health care than for physical health care.[22] According to a report by the General Accounting Office, Congress's investigative agency, eighty-seven percent of health plans offer less favorable terms for mental health care than for physical health care, with higher cost-sharing or more limitations on access.[23] Even if you rely on Medicare, it will cost you more in out-of-pocket co-payments to seek treatment for mental illnesses.[24]

Congress took its first stab at addressing this disparity in the Mental Health Parity Act of 1996 (MHPA).[25] That Act prohibited health plans from offering lower annual or lifetime benefits for mental health coverage than for physical health coverage.[26] For example, if the plan otherwise paid up to $1 million for medical services, it could no longer cap mental health coverage at $50,000. While this provision was an important first step toward ending insurance discrimination, its impact was slight. The GAO found that most plans came into compliance by imposing additional treatment limits or cost-sharing for mental health care, both of which remained legal under the MHPA.[27]

The bill that I have introduced in the House of Representatives[28] and Senator Pete Domenici (R-N.M.) has introduced in the Senate,[29] the Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003,[30] would close this massive loophole in the MHPA, and require most health plans[31] that choose to cover mental health to end the discrimination between mental health and physical health coverage.[32] No longer, for example, would

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[21] *See id.* at 7.

[22] *See* U.S. Gen. Accounting Office, Mental Health Parity Act: Despite New Fededal Standards, Mental Health Benefits Remain Limited 3 (May 2000) [hereinafter GAO Report].

[23] Id., at 5.

[24] 42 U.S.C. § 1395l(c) (2000).

[25] Pub. L. No. 104-204, 110 Stat. 2944 (1996).

[26] *See* Mental Health Parity Act, Pub. L. No. 104-204, Title VII, § 702(c), 110 Stat. 2947 (codified as amended at 29 U.S.C. § 1185a(a) (2000)); *see id.* at Title VII, § 703(a), 110 Stat. 2947 (codified as amended at 42 U.S.C. § 300gg-5(a) (2000)).

[27] *See* GAO REPORT, *supra* note 22, at 12 (finding that sixty-five percent of plans that changed annual or lifetime limits to come into compliance with the MHPA made another feature of their plans more restrictive).

[28] H.R. 953, 108th Cong. (2003).

[29] S. 486, 108th Cong. (2003).

[30] Senator Domenici and I named the bill after Senator Paul Wellstone (D-Minn.), who was a passionate, tireless champion of mental health parity prior to his death in a plane crash in 2002.

[31] *See* H.R. 953 § 2. Small businesses, defined as those with fewer than 50 employees, are exempt from the provisions of the Wellstone Act. *See id.*

[32] *See id.* (excluding, as a concession to political realities, substance abuse diagnoses from its terms, despite their frequent co-morbidity with other mental illnesses and the fact

plans be able to require patients to pay 50% coinsurance for mental health outpatient services when other outpatient services require only 20% in cost-sharing,[33] or cap psychiatric inpatient stays at thirty days while allowing unlimited stays for treatment of other conditions.[34] The legislation also amends the Employee Retirement Income Security Act (ERISA) to correct for the fact that although many states have parity laws on the books of varying strength, ERISA preempts state regulation of many large employers.[35] The Wellstone Act's provisions would instead apply to all health plans serving groups of fifty or more, even if otherwise covered by ERISA.[36] At long last, under our parity legislation, the health care sector would recognize that Descartes was wrong and that mind and body are inextricably intertwined.[37]

THE PRINCIPLED CASE FOR PARITY

In the face of a growing body of scientific literature documenting the biochemical nature of mental illnesses, the status quo of insurance discrimination against those who suffer from such illnesses is indefensible. Former Surgeon General David Satcher wrote in his landmark report that the distinction between mind and body is arbitrary and not supported by science.[38] Indeed, brain research from the National Institute of Mental Health continues to illuminate the physiology of mental illnesses.[39] Yet our insurance policies continue to treat diseases of the brain as less worthy of coverage than diseases of other systems or organs.[40]

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that addictive disorders can be considered to be a subset of mental disorders).

[33] *See* GAO REPORT, *supra* note 22, at 12 (finding that more than a quarter of private health plans require greater cost-sharing for mental health care than physical health care); *see also* Colleen L. Barry et al., *Design of Mental Health Benefits: Still Unequal After All These Years*, HEALTH AFFAIRS, Sept.-Oct. 2003, at 127, 129 (finding that 22% of private health plans have greater cost-sharing for mental health care).

[34] *See* GAO REPORT, *supra* note 22, at 5; *see also* Barry et al., *supra* note 33 at 129 (finding that 65% of private health plans restrict hospital stays and 64% restrict outpatient visits for mental health care further than for physical health care).

[35] 29 U.S.C. § 1144(a) (2000) (stating that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA).

[36] *See* H.R. 953 § 2.

[37] *See* SGRMH, *supra* note 2, at 2.

[38] *Id.* at 5–6.

[39] *See, e.g.*, NAT'L INST. OF MENTAL HEALTH, SCHIZOPHRENIA RESEARCH 2 (May 2000) (noting that NIMH investigators have "recently discovered specific, subtle abnormalities in the structure and function of the brains of patients with schizophrenia"); NAT'L INST. OF MENTAL HEALTH, BIPOLAR DISORDER RESEARCH 4 (Apr. 2000), (concluding that "[o]ne of the most consistent findings to date has been the appearance of specific abnormalities, or lesions, in the white matter of the brain in patients with bipolar disorder"); NAT'L INSTITUTE OF MENTAL HEALTH, ANXIETY DISORDER RESEARCH 3 (August 1999) (finding that animal research suggests "different anxiety disorders may be associated with activation in different parts of the amygdala [a structure in the brain]").

[40] *See supra* text accompanying note 33.

Discrimination in health insurance has immediate and drastic consequences for millions of people, pricing many out of the care they need.[41] I have heard too many stories like that of Katie Westin, a girl with anorexia who was prematurely discharged from a hospital when she exhausted her mental health benefits.[42] Lacking the medical care that had been slowly helping her get better, she lost her battle with anorexia and her body eventually shut down.[43]

While not all mental illnesses take as vicious a toll on the body as anorexia, the specter of suicide makes many afflictions potentially lethal. For every two homicides in this country, there are three suicides.[44] More than 30,000 Americans commit suicide every year; in 2001, it was the eleventh leading cause of death in the United States, the cause of 1.3% of all deaths.[45] Given that ninety percent of those who kill themselves have a mental illness, these statistics reveal the dangers of letting such illnesses go untreated.[46]

Even when they do not end lives, untreated mental illnesses can destroy them. As anybody who has walked down a city street knows, mental illness makes itself felt in the epidemic of homelessness. During any given week, an estimated 850,000 Americans sleep on the streets, twenty to twenty-five percent of whom have severe mental illnesses.[47] The inadequacy of mental health care has also made jails and prisons the de facto mental institutions of our age. The single largest mental health provider in the nation is the Los Angeles County jail.[48] The Department of Justice estimated in 1999 that more than a quarter of a million inmates in American jails and prisons have serious mental illnesses.[49] Among young inmates,

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[41] *See, e.g.*, Deborah Jasper & Spencer Hunt, *Everything Spent, and No Help*, Cincinnati Enquirer, Mar. 21, 2004 ("When her insurance ran out, she sold her $287,000 suburban home to cover treatment for both of her sons, who have bipolar disorders that cause them to swing from overly hyper to depressed or violent."), *available at* http://www.enquirer.com/editions/2004/03/21/mentalhealth/loc_mentalmikolic.html. The cost of residential treatment programs can exceed $250,000 per year. U.S. Gen. Accounting Office, *supra* note 3.

[42] *See* Kitty Westin, Remarks About Her Daughter's Eating Disorder at Press Conference Introducing H.R. 953 (Feb. 27, 2003); *see also* Kitty Westin, *When Your Child Dies of an Eating Disorder: A Mother's Story*, *in* EATING DISORDERS COALITION, A MATTER OF LIFE OR DEATH: A CONGRESSIONAL BRIEFING ON EATING DISORDERS AND ACCESS TO CARE 1 (June 13, 2002) [hereinafter Westin], *available at* http://www.eatingdisorderscoalition.org/congbriefings/061302/housebriefing061302.html#westin (last visited Apr. 20, 2004).

[43] *See* Westin, *supra* note 42.

[44] Elizabeth Arias, *Deaths: Final Data for 2001*, 52 NAT'L VITAL STAT. REP. 8 (Sept. 18, 2003), *available at* http://www.cdc.gov/nchs/data/nvsr/nvsr52/nvsr52_03.pdf.

[45] *Id.*

[46] SOUTHCENTRAL COUNSELING CTR., MENTAL HEALTH MATTERS FACT SHEET, *at* http://www.southcentralcounseling.org/mental_health_info.htm (last modified July 15, 2002).

[47] NAT'L RES. CTR. ON HOMELESSNESS & MENTAL ILLNESS, GET THE FACTS: WHO IS HOMELESS? 1, *available at* www.nrchni.samhsa.gov/facts/facts_question_2.asp (last modified June 6, 2003).

[48] L.A. COUNTY SHERIFF'S DEP'T, AUTOMED, *at* http://www.lasd.org/divisions/correctional/medical_srvs/ovrview.html#automed (last visited Apr. 20, 2004).

[49] PAULA M. DITTON, U.S. DEP'T OF JUSTICE, SPECIAL REPORT: MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS 1 (July 1999), *available at* http://www.ojp.

the numbers are perhaps even more disheartening: research shows that as many as one in five incarcerated youth have a serious mental health disorder, such as schizophrenia, major depression, or biopolar disorder.[50]

These are some of the consequences of our discrimination in health coverage. But these statistics do not speak to consequences more difficult to quantify—the broken families, the lost potential, the denial of participation in civic life. How to measure the heartbreak of parents forced to trade custody of their children to the state in exchange for potentially life-saving care?[51] In 2001, more than 12,700 children were placed in state custody solely to obtain mental health services, and private health insurance limitations have been identified as common catalysts for such difficult decisions.[52] Similarly, statistics cannot measure the impact of being fired for seeking counseling, or suffering other such discriminatory acts on a day-to-day basis. Forty-five percent of respondents in a recent study of the mentally ill reported that stigma and discrimination were barriers to employment.[53] Similar research revealed that 37.7% individuals with serious mental illnesses reported having suffered discrimination wholly or in part based on their mental illness in areas such as employment, housing, and interactions with law enforcement.[54]

As we have rejected other discriminatory policies, so must we reject discrimination against those with mental illnesses, and mental health parity is a key step in doing so. Under current policy, our health care system suggests that mental health care falls somewhere between cosmetic surgery, which is not covered at all, and "real" health care. Coming from the health care system itself, this is a powerful signal to the rest of society, including the mentally ill themselves. According to the Surgeon General's report, two-thirds of those with mental illnesses do not seek treatment,[55] and a leading reason is the stigma of mental illness.[56] Passage of mental health parity legislation would emphasize, as few other steps could, that there is no valid distinction to be drawn between mental and physical

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usdoj.gov/bjs/pub/pdf/mhtip.pdf.

[50] Joseph. J. Cocozza & Kathleen Skowyra, *Youth With Mental Health Disorders: Issues and Emerging Responses*, JUVENILE JUSTICE, Apr. 2000, at 3, 6.

[51] *See* BAZELON CTR. FOR MENTAL HEALTH LAW, RELINQUISHING CUSTODY: THE TRAGIC RESULT OF FAILURE TO MEET CHILDREN'S MENTAL HEALTH NEEDS 11 (Mar. 2000) (finding that families who turn to the public system for assistance when their children's intensive mental health needs quickly deplete their insurance often must relinquish custody to the state before assistance is made available).

[52] U.S. GEN. ACCOUNTING OFFICE, *supra* note 3.

[53] NAT'L ALLIANCE FOR THE MENTALLY ILL, SHATTERED LIVES: RESULTS OF A NATIONAL SURVEY OF NAMI MEMBERS LIVING WITH MENTAL ILLNESSES AND THEIR FAMILIES 20 (July 2003).

[54] Patrick Corrigan et al., *Perceptions of Discrimination Among Persons with Serious Mental Illness*, PSYCHIATRIC SERVICES, Aug. 2003, at 1102, 1105.

[55] SGRMH, *supra* note 2, at 8.

[56] PRESIDENT'S NEW FREEDOM COMM'N ON MENTAL HEALTH, ACHIEVING THE PROMISE: TRANSFORMING MENTAL HEALTH CARE IN AMERICA 21 (2003) ("Stigma is a pervasive barrier to understanding the gravity of mental illnesses and the importance of mental health.").

health. More than simply serving as a symbol of our intolerance for discrimination, though, parity would break down the barriers to mainstream America thrown up by mental illness. By increasing access to appropriate care, we also increase access to hope, opportunity, and the future.

THE PRACTICAL CASE FOR PARITY

For the end it would put to one of the most visible and damaging examples of discrimination today and for the larger symbolic blow it would strike for equality for those with mental illness, Congress should pass the Wellstone Act. But parity is not only well justified as a civil rights measure, it also makes good sense as a matter of health policy. For as long as stigma clouds decision-making around mental health, the majority of businesses will maintain a status quo that is as harmful in economic terms as it is in terms of health.

A few years ago, the World Health Organization, the World Bank, and Harvard Medical School teamed up to study the impact of disease.[57] Rather than simply measuring which diseases killed the most people, the Global Burden of Disease study looked at which diseases stole the greatest number of years of healthy life, through either premature death or disability.[58] They discovered that mental illnesses created the second-greatest burden of any class of diseases in industrialized nations, surpassed only by cardiovascular conditions and exceeding even cancers.[59] Moreover, they determined that mental illnesses and substance abuse together cause more lost days of healthy life than any other cause.[60]

Not surprisingly, then, the costs of mental illness to society are staggering. Although good numbers are hard to come by, it is safe to estimate that mental illnesses cost the United States at least $200 billion per year. In 1996, the direct cost of treating mental illnesses was $69 billion.[61] Since then, medical inflation has caused an increase in health care costs of more than twenty-five percent.[62] Moreover, spending on antidepressant drugs increased by more than twenty percent *each year* between 1999 and 2001, the most recent year for which data is available.[63] Given the explosion of psychopharmacological treatments, one can conservatively

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[57] *See* SGRMH, *supra* note 2, at 4.

[58] *See id.*

[59] *See id.*

[60] *See id.*

[61] SGRMH, *supra* note 2, at 49.

[62] BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, CONSUMER PRICE INDEX—ALL URBAN CONSUMERS (2004), *available at* http://data.bls.gov/cgi-bin/surveymost?cu.

[63] NAT'L INST. FOR HEALTH CARE MGMT. RESEARCH & EDUC. FOUND., PRESCRIPTION DRUG EXPENDITURES IN 2001: ANOTHER YEAR OF ESCALATING COSTS 12 (May 6, 2002), *available at* http://www.nihcm.org/spending2001.pdf; NAT'L INST. FOR HEALTH CARE MGMT. RESEARCH & EDUC. FOUND., PRESCRIPTION DRUG EXPENDITURES IN 2000: THE UPWARD TREND CONTINUES 16 (May 2001), *available at* http://www.nihcm.org/spending2000.pdf.

assume that mental health costs as a whole have, at a minimum, kept even with medical inflation. Thus, a twenty-five percent increase in direct mental health care costs since 1996 yields a staggering $86 billion in direct costs today. Indirect costs, such as lost productivity, disability claims, and social program spending, were estimated in 1998 to be $113 billion annually.[64]

Lost productivity is the largest cost component resulting from a failure to address the problem of mental illness adequately. A recent study in the *Journal of the American Medical Association* examined the impact of depression on businesses, and concluded that while non-depressed workers average 1.5 hours per week of lost productivity due to health problems, workers with depression average 5.6 such hours.[65] This lost productivity due to depression, the authors conclude, cost businesses an estimated $31 billion per year.[66] Moreover, most of the lost productivity takes the form of "presenteeism," where people are at work but not working efficiently, rather than the more obvious absenteeism.[67] The result is that much of the lost productivity is invisible to employers.[68]

These estimates count only the cost to businesses of lower productivity, but there are also out-of-pocket costs to employers that result from allowing mental health needs to go untreated. As might be expected for the second-leading cause of disability nationwide, mental illnesses are a significant part of overall disability costs. A 1998 study determined that employers whose health plans offer relatively good access to outpatient mental health services have lower psychiatric disability claims costs than plans that maintain more restrictive arrangements.[69]

Paradoxically, skimping on mental health care may even raise overall health care costs. A study of more than 46,000 workers at major U.S. companies showed that employees who report being depressed or under stress are likely to have substantially higher health-care costs than coworkers without such ailments.[70] Employees who reported being depressed had health bills that were 70% higher than those who did not suffer from depression, and those reporting high stress had 46% higher

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[64] Dorothy P. Rice & Leonard Miller, *Health Economics and Cost Implications of Anxiety and Other Mental Disorders in the U.S.*, 172 BRIT. J. PSYCHIATRY 4, 4–9 (1998).

[65] Walter F. Stewart et al., *Cost of Lost Production Work Time Among U.S. Workers With Depression*, 28 J. AM. MED. ASS'N 3135, 3140 (2003).

[66] *See id.* at 3141.

[67] *See id.*

[68] *See id.*

[69] DAVID SALKEVER, UNUM LIFE INS. CO., PREDICTORS AND DESCRIPTORS OF PSYCHIATRIC DURATION, COST AND OUTCOMES STUDY (1998), *cited in* Mary Jane England, *Capturing Mental Health Cost Offsets*, HEALTH AFFAIRS, Mar. 1999, at 91, 92, *available at* http://content.healthaffairs.org/ cgi/reprint/18/2/91.pdf.

[70] Ron Z. Goetzel et al., *The Business Case for Quality Mental Health Services: Why Employers Should Care About the Mental Health and Well-Being of Their Employees*, 44 J. OCCUPATIONAL & ENVTL. MED. 320, 324 (2002).

health care costs.[71] Another study found that when workers with depression were treated with prescription medicines, annual medical costs declined by $822 per worker.[72]

Research by the National Institute of Mental Health into the connections between mental and physical diseases suggests a potential explanation. Depression, the most prevalent and most studied mental illness, may worsen high blood pressure,[73] and men with psychological distress are as much as three times more likely to suffer a fatal stroke than counterparts without such symptoms.[74] On average, people with depression are four times more likely to have a heart attack than those with no history of depression.[75]

In addition to the price that businesses pay, perhaps unwittingly, for the relative inaccessibility of mental health care, there are significant costs that society as a whole must bear, and not only in the costs associated with criminal justice and homelessness described above.[76] There is a heavy burden created by the unemployment of the mentally ill. In 2002, President Bush appointed a commission to examine barriers to mental health care and to make recommendations for improvements. The commission concluded that

> undetected, untreated, and poorly treated mental disorders interrupt careers, leading many into lives of disability, poverty, and long-term dependence. Our review finds a shocking 90 percent unemployment rate among adults with serious mental illness—the worst level of employment of any group of people with disabilities. Strikingly, surveys show that many of them want to work and report that they *could* work with modest assistance.[77]

The results of this needlessly high unemployment rate include public expenditures on disability payments and income supports, as well as lost tax revenue, all of which could be obviated by better mental health care.

While the costs to business and society of poor mental health care are significant, the price tag on mental health parity legislation is relatively small. The Congressional Budget Office has estimated that the bill I have

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[71] *Id.*

[72] John A. Rizzo et al., *Labour Productivity Effects of Prescribed Medicines for Chronically Ill Workers*, 5 HEALTH ECON. 249, 250 (1996).

[73] Jose Juan Lozano et al., *Meeting Report: Depression May Worsen High Blood Pressure* (Apr. 28, 2003), *at* http://www.americanheart.org/presenter.jhtml?identifier=3011335.

[74] Margaret May et al., *Does Psychological Distress Predict the Risk of Ischemic Stroke and Transient Ischemic Attack?: The Caerphilly Study*, 33 STROKE 7, 8–12 (2002).

[75] Laura A. Pratt et al., *Depression, Psychotropic Medication, and Risk of Myocardial Infarction*, 94 CIRCULATION 3123, 3127 (1996).

[76] *See supra* text accompanying notes 46–49.

[77] PRESIDENT'S NEW FREEDOM COMM'N ON MENTAL HEALTH, INTERIM REPORT TO THE PRESIDENT 11 (Oct. 29, 2002) (*citing* R. E. Drake et al., *Research on the Individual Placement and Support Model of Supported Employment*, 70 PSYCHIATRIC Q., 289, 299 (1999)).

introduced would raise group health insurance premiums by 0.9%.[78] Employers' premiums are predicted to increase by a mere 0.36%.[79] A study by PricewaterhouseCoopers echoes the CBO estimate, pegging the cost of parity legislation at 1%, or $1.32 per member per month.[80] With health care premiums predicted to continue rising by double-digit percentages annually, the difference parity would make falls within the estimates' margin of error.[81]

In fact, the experience of states that have implemented parity legislation confirms the reasonableness of these estimates. Some examples:

In 1998, Vermont instituted a far-reaching mental health and substance abuse parity law, which the U.S. Department of Health and Human Services recently found lowered mental health and substance abuse spending by 8% to 18% while increasing access to mental health care by 18% to 24%.[82]

In Maryland, after a small rise of less than one percentage point in the year of transition to parity, mental health costs held steady in year two and declined in year three.[83]

In Ohio, behavioral health costs for HMO enrollees fell following implementation of full mental health and substance abuse parity in 1993 and 1997, perhaps in part due to a nearly 50% drop in the number of inpatient days paid for.[84]

Those who would oppose parity legislation argue that if mental health care is so cost-effective, such legislation should not be necessary; the market would demand better mental health coverage because it would

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[78] JENNIFER BOWMAN ET AL., CONGRESSIONAL BUDGET OFFICE, CONGRESSIONAL BUDGET OFFICE COST ESTIMATE—S. 543 MENTAL HEALTH EQUITABLE TREATMENT ACT OF 2001, at 3 (Aug. 1, 2001), *available at* http://www.cbo.gov/showdoc.cfm?index=3013&sequence=0.

[79] *See id.* (estimating that costs would increase 0.9%, but 60% of that cost would be offset by behavioral responses from employers and employees).

[80] AM. PSYCHOLOGICAL ASS'N, THE COST OF FULL PARITY: 1–2%, OR LESS. PERIOD. (Mar. 2002), *at* http://apa.org/practice/parity_cost.html (*citing* PRICEWATERHOUSECOOPERS, AN ACTUARIAL ANALYSIS OF S. 543, MENTAL HEALTH EQUITABLE TREATMENT ACT OF 2001, at 6 (2001)).

[81] *See* HENRY E. SIMMONS & MARK A. GOLDBERG, NAT'L COALITION FOR HEALTH CARE, CHARTING THE COST OF INACTION 5 (May 19, 2003) (predicting average annual premiums for employer-provided coverage through 2006), *available at* http://www.nchc.org/materials/studies/Cost_of_Inaction_Full_Report.pdf.

[82] CTR. FOR MENTAL HEALTH SERVS. & CTR. FOR SUBSTANCE ABUSE TREATMENT, U.S. DEP'T OF HEALTH & HUMAN SERVS., EFFECTS OF THE VERMONT MENTAL HEALTH AND SUBSTANCE ABUSE PARITY LAW 58 (2003), *available at* ftp://ftp.health.org/pub/ken/pdf/SMA03-3822/CMHS9PRI.pdf.

[83] *See* HAROLD E. VARMUS, NAT'L. INSTS. OF HEALTH, PARITY IN FINANCING MENTAL HEALTH SERVICES: MANAGED CARE EFFECTS ON COST, ACCESS AND QUALITY 11 (May 1998).

[84] Roland Sturm et al., *Mental Health and Substance Abuse Parity: A Case Study of Ohio's State Employee Program*, 1 J. MENTAL HEALTH & ECON. 129, 132 (1998).

save on these other costs. The nature of mental illnesses, however, masks the costs and distorts normal market forces. First, as explained above, while there are great savings to be realized to companies' bottom lines overall, a great deal of the savings takes the form of productivity gains, which are harder to quantify than the health care expenditures with which they must be compared.[85] Moreover, as the Stewart study noted, a significant portion of the cost to employers of the status quo is invisible, because it involves "presenteeism."[86] Most importantly, though, as the Surgeon General wrote, "The stigma that envelops mental illness deters people from seeking treatment .... Powerful and pervasive, stigma prevents people from acknowledging their own mental health problems, much less disclosing them to others."[87] Out of simple embarrassment or justifiable fear of repercussions, employees with mental illnesses are far less likely to advocate for better coverage, as would employees with other diseases. Irrational prejudices can trump rational economic decision-making.

Where businesses have endeavored to improve their mental health care, they have seen favorable results. James Hackett, the CEO of Ocean Energy, said in explaining the decision of his firm and two other Houston companies to offer full parity between mental and physical health benefits, that the increase in annual health costs is "more than offset by avoided costs of lost employee productivity."[88] As long as stigma clouds decision-making around mental health, however, we can expect the majority of businesses to maintain the harmful status quo, making parity legislation necessary.

CONCLUSION

One major subtext of our national history is the struggle between the lofty principles on which our country was founded and the baser human instincts that have prevented us from reaching our founding ideals. What makes America great is that over time, we have consistently striven to move closer to achieving in reality the equality and opportunity promised to all in theory. It is time for us to take another such step and open the American dream to those who are afflicted with mental illnesses.

We can draw a direct line from the coverage limitations on mental health care to untreated mental illness to needless suicides, imprisonment, unemployment, and broken relationships. In an era when researchers are churning out ever more science exploring the biochemical and physiological causes and effects of mental illnesses, there is no excuse

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[85] *See* STEWART, *supra* note 65, at 3140.

[86] See *supra* text accompanying notes 65–68.

[87] SGRMH, *supra* note 2, at 454.

[88] *Insurance Coverage of Mental Health Benefits: Hearings Before the House Comm. on Energy and Commerce*, 107th Cong. 37 (2002) (prepared statement of James T. Hackett; Chairman, President, and CEO; Ocean Energy, Inc.).

for such differential treatment. By accepting the status quo, we as a society make a choice to deny effective health care to a disfavored class. That choice is a blot on our honor and a betrayal of our principles.

The Wellstone Act would repair this hole in the civil rights fabric of our country while also strengthening our health care system. The exclusion of diseases of the brain from health care is inefficient and costly. While it is possible that health savings of mental health parity will fully offset the additional costs it entails, it is a virtual certainty that the *overall* savings of parity—including greater productivity, fewer disability claims, and the myriad social benefits discussed above—will far outweigh the modest costs arising from increases in use of mental health care services. Indeed, as the Surgeon General and many others have noted, we already bear the costs generated by untreated mental illnesses. It would be more efficient and more humane to pay those costs in the form of effective treatment than it is to disburse funds for incarceration, disability payments, and welfare.

Forty-one years ago, on February 5, 1963, President Kennedy said: "We as a Nation have long neglected the mentally ill and the mentally retarded. This neglect must end, if our Nation is to live up to its own standards of compassion and dignity and achieve the maximum use of its manpower."[89] President Kennedy's words still hold force today. At the time, he was calling for deinstitutionalization, arguing that we must bring our mentally ill family members, friends, and neighbors back into our communities. We have made strides in forty years toward bringing Americans with mental illness into our physical communities, but we must complete that journey by bringing them into the mainstream of American life. Throughout our history we have measured ourselves against the principles we cherish, against "[our] own standards of compassion and dignity," and, though not without difficulty, improved our nation when we found ourselves falling short.[90] It is time to pass the Wellstone Act and take another step forward.

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[89] Special Message to the Congress on Mental Illness and Mental Retardation, 50 PUB. PAPERS (Feb. 5, 1963), *available at* http://www.presidency.ucsb.edu/site/docs/pppus.php?admin=035&year=1963&id=50.

[90] *Id.*